OMM Hands on Session- Cervicalgia

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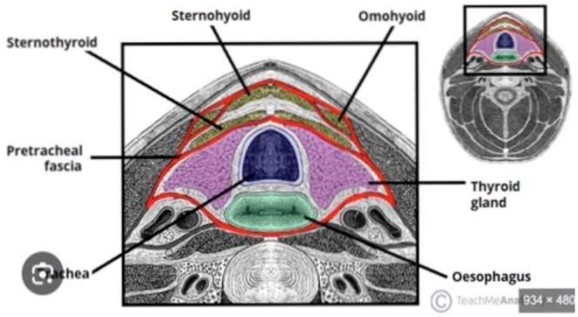
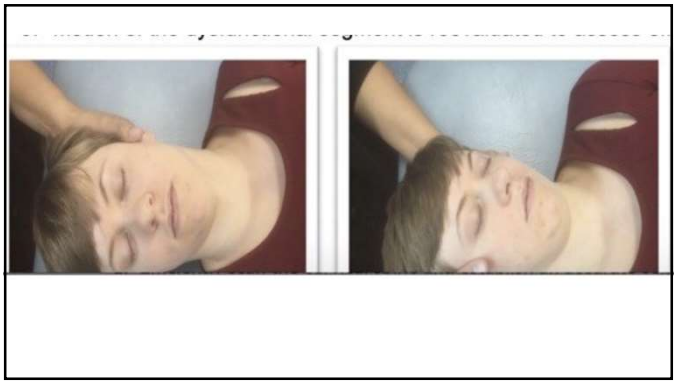


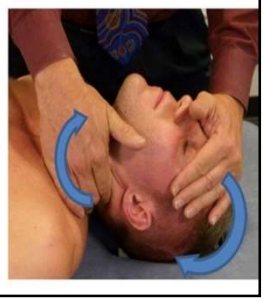
1. The physician locates and monitors the articular pillars of the dysfunctional segment with one hand.
2. With the other hand, the physician passively sidebends and rotates the patient to the feather's edge of the restrictive barrier utilizing the head.
3. The physician, through their contact with the patient's head, passively flexes or extends the patient's cervical spine until flexion/extension is induced at the dysfunctional segment.
4. The patient attempts to "return to neutral" or "straighten out" as the physician applies an unyielding counterforce maintaining a monitoring contact at all times. Alternatively, the physician can have the patient provide isometric muscle contraction into the ease in sidebending or rotation, whichever they deem is the more restricted element.
5. The isometric contraction is maintained for 3 to 5 seconds, and then the patient is instructed to stop and relax.
6. Once the patient has completely relaxed, the physician repositions the patient to the feather's edge of the restrictive barrier in both sidebending and rotation.
7. Steps 7 to 9 are repeated three to five times or until motion is maximally improved at the dysfunctional segment.
8. A final stretch is applied through the restrictive barrier focally at the dysfunctional segment.
9. Motion of the dysfunctional segment is reevaluated to assess effectiveness of the technique.



Supine Kneading and Stretching One Hand on Forehead / "Cervical Push-Pull" stretch

Standing on the contralateral side of a supine patient:

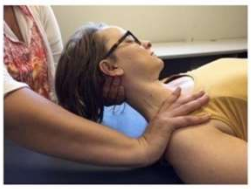
1. Caudal hand of the physician contacts and engages contralateral
   cervical paravertebral muscle by lifting anteriorly while the
   cephalad hand rests gently on the patient's forehead and
   rolls the patient's forehead away, meeting and matching the tension created by the caudal hand's kneading motion.
2. Move rhythmically superior and inferior to relax tissues.
3. Reasses.s



Supine Unilateral Stretch of Cervical Spine

Standing at the head of the supine patient:

1. The physician's ipsilateral hand gently engages cervical tissues by pushing the patient's shoulder caudally.
2. The physician's cephalad hand gently engages cervical tissues by lifting the head and neck anteriorly and to the side opposite of the stabilized shoulder creating a stretch and waiting for release.
3. May relax the tension and repeat as necessary.
4. Reassess.



Variation is to use the contralateral hand to stabilize the shoulder and engage cervical tissues while using the cephalad hand to gently engage cervical tissues by lifting head and neck anteriorly and to the side opposite of the stabilized shoulder, balancing tensions and waiting for release.

These stretches can really engage the levator and the scalenes; **go gently and slowly.**

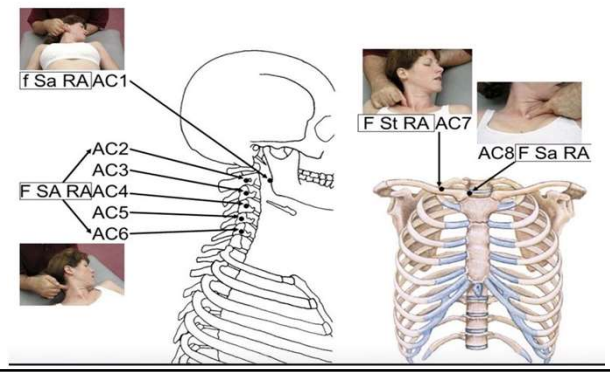
Principles of soft tissue technique:

1. Instruct the patient to position themselves comfortably on the table (seated, prone, lateral recumbent, supine, etc.)
2. Sit /stand in a manner that maximizes your ability to contact the part of the patient to be treated and that minimizes your postural stress
3. Apply the minimum force needed to contact the tissue being treated and not cause pain
4. Apply force in the correct vector for the technique
5. Sustain or alter the force until the desired effect is achieved
6. Reduce the force to allow the process to begin anew (when appropriate)
7. Repeat the process in a rhythmic fashion until the desired effect is obtained (when appropriate)

PEARLS: 1) Pay attention to the FEEL of the tissue. That's it!

Suboccipital Release / Inhibition

1. Patient is supine. Doctor is seated at the head of the bed/table.
2. Doctor places finger pads just inferior to the patient's superior nuchal line in the suboccipital muscles.
3. Lift weight of head onto your fingers making sure to maintain the curve of the joints of your fingers. The head should be off of your palms.
4. Using their forearms as a fulcrum the doctor adds a small amount of cephalad traction by leaning back.
5. Wait for relaxation of the suboccipital muscles and settling of the head into your palms.
6. Reassess tissue tension



•OMM Hands on Session
Lumbago

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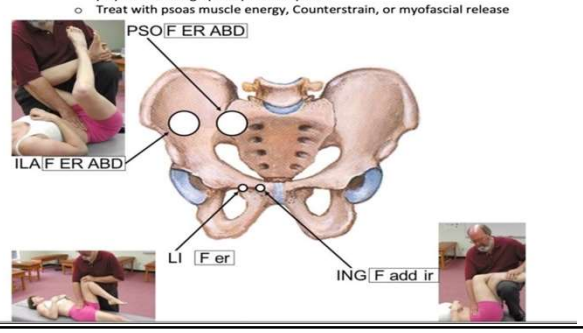
- Psoas Syndrome
  - Psoas testing: Thomas test, palpation for psoas Counterstrain point, or layer palpation through paraspinals to psoas
  - Treat with psoas muscle energy, Counterstrain, or myofascial release

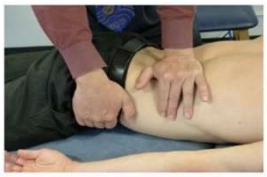


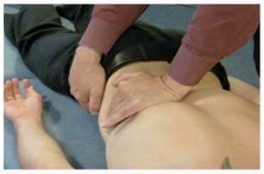
Techniques:

Kneading and Stretching: Prone with Counter Leverage

Standing on the contralateral side of a prone patient:

1. Identify the anterior superior iliac spine of your patient and gently wrap the finger pads of your caudal hand medially to the ASIS.
2. Engage, with the heel of your cephalad hand, the paraspinal muscles (being careful to be immediately lateral to the spinous processes).
3. Then, with your caudal hand lift the pelvis and with your cephalad hand knead the paraspinal muscles, meeting tension from below and tension from above while moving rhythmically up and down the spine with your cephalad hand.
4. Reassess.





Supine LS Decompression

i. For this technique, the patient will be standing at the side of the table facing the patient.
ii. Assess the lumbosacral junction with light springing over the junction.
iii. The cephalad arm will conform to the patient's sacrum so that the hand is centered on the sacrum while the caudad hand will cross it to contact the lumbar spine.
iv. Once you have your hands contacting the lumbar spine and the sacrum, position the sacrum and the lumbar spine in slight traction by putting gentle pressure in opposite directions.
v. Then add lumbosacral decompression by adding inferior traction and or superior traction at the lumbar sacral junction to decompress that joint.
vi. Once you have created a sense of increased space at the lumbosacral junction, you may note a release or an increase of amplitude of the PRM.
vii. Once you have appreciated this release, relax your hands and allow tensions to return to neutral and reassess your patient.

- Seated Still Technique for lumbars and sacrum
  - Diagnose with the patient seated or prone. For the sacrum, this can be as simple as the Seated Flexion Test to lateralize the dysfunctional side.
  - Lumbars: monitor the dysfunctional lumbar segment. Have the patient cross their arms so that their elbows are together in front of their chest. Add flexion/extension, sidebending and rotation to ease. Add compression or traction to the point of more ease, then move through the restrictive barrier in an arc and return to neutral. Recheck.
  - Sacrum: monitor the restricted SI joint. Have the patient cross their arms so that their elbows are together in front of their chest. Add flexion/extension, sidebending and rotation of the torso, while monitoring the SI joint until the tissue changes are significantly improved. Add compression or traction to the point of more ease, then move through the restrictive barrier in an arc and return to neutral. Recheck.
  - For adding compression, place your arm across the patient's shoulders and push down in a vector towards the dysfunctional segment.
  - For adding traction, place your hand under the patient's elbows and stand up, which adds traction without undue exertion. Make sure to keep the traction in an axial direction so that you don't extend the spine.

- Tips for the Still technique
  - Fine tune ease as much as possible, using small motions
  - For compression and traction, adjust pressure gradually until you feel the tissue response. If you don't add enough or if you add too much, the tissues will tighten up. If you feel like you have overshot, go back to the beginning ease position and try to increase the pressure gradually
  - Make sure to use an arc of motion (don't go from point A to point B in a straight line)—arc probably helps with the motion of the facets